

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008733
STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. 297 Primary Registration District No. 3057 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY RAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY RAY	
b. CITY OR TOWN Richmond		c. CITY OR TOWN HARDIN	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION CLEMENS REST Home		d. STREET ADDRESS 4 MILES NORTH OF HARDIN	

3. NAME OF DECEASED (Type or print) First William Middle WARNER Last WALL			4. DATE OF DEATH MARCH 1, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1884		9. AGE (In years last birthday) 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER BUSINESS		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) RAY COUNTY, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME OCTAVIUS WALL		13b. MOTHER'S MAIDEN NAME AGNES GAER		14. NAME OF HUSBAND OR WIFE MARY WALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 492-44-3200		17. INFORMANT VIRGINIA B. WALL - CHILLICOTHE, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b) ? DUE TO (c) ?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) ?	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from 2-10-59 to 3-1-59 and last saw her/him alive on 2-28-59 Death occurred at 3-1-59 11:50 AM on the date stated above and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS Richmond		22c. DATE SIGNED 3-3-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-3-59		23c. NAME OF CEMETERY OR CREMATORY LAVEROCK CEM.	
		23d. LOCATION (City, town, or county) RAY COUNTY, Mo.		(State)	

24. FUNERAL DIRECTOR KNIPSCHILD BORCHERDINO ADDRESS HARDIN, Mo.		25. DATE RECD. BY LOCAL REG. 3-5-1959		26. REGISTRAR'S SIGNATURE Malcolm Jackson	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

See reverse side for instructions. All diseases in Part I must be causally related.

300
1-57

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *August Boucherding*

Licensed Embalmer No. *4678*

P. O. Address *Hardin, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.